DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9693 1127

FILED APR 12 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital No.1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether In this community years, months or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 1433 Prospect (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME Burton Eldred 436

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lynthia Belle Eldred

6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased Jan. (Month) 31. (Day) 1864 (Year)

8. AGE: Years	Months	Days	If less than one day
76	11	11	hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Proprietor Rooming House

11. Industry or business

MOTHER FATHER

12. Name Ambrose Sidney Eldred

13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

14. Maiden name Ruth Hall

15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant's own signature Mrs Minnie J. Beebe

(b) Address 1433 Prospect

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof March 12, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) Mch 11, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11th year 1940 hour 5 minute 51 P. M.

21. I hereby certify that I attended the deceased from 3-5-40, 19..., to 3-11-40, 19...; that I last saw him alive on 3-11-40, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic bronchopneumonia with pulmonary congestion and edema	
Due to Chronic vascular nephritis 15 1	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:

Of operations

Of autopsy See above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Geo. Mann M.D. (M. D. or other)

Address Supt. K.C. Gen. Hospital, K.C. Mo. Date signed 3-12-40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed C. L. Nice

Licensed Embalmer No. # 2-70

P. O. Address Kansas City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.